GUIDELINES FOR THE COMPLETION OF

THE INDIVIDUALIZED SUPPORT PLAN

BUREAU OF DEVELOPMENTAL DISABILITIES SERVICES

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GUIDELINES FOR THE COMPLETION OF THE "INDIVIDUALIZED SUPPORT PLAN"

What are the elements of Person Centered Planning?

The basic elements of a person centered planning are:

- discovering the person
  - individual's vision: what works; what doesn't work; likes/dislikes; biggest fears; negotiables/non-negotiables
  - documenting all information gathered during the process
  - identifying existing supports consistent with the individual achieving identified goals
  - issues of safety, health, rights and freedom from abuse, neglect and exploitation are dealt with
- action/support plan
  - additional supports needed
  - strategies
  - timelines

Please note: for a more detailed discussion of Person Centered Planning see the June 2001 edition of ***Person Centered Planning Guidelines***.

What is an "Individualized Support Plan"?

In Indiana, it is expected that each individual with a developmental disability who is receiving long term support services funded and/or monitored by the Division of Disability, Aging and Rehabilitative Services (DDARS) of the Family and Social Services Administration (FSSA), will have an "Individualized Support Plan". The individualized support plan documents the results of the "Person Centered Planning" (PCP) process. It is developed before the budget is prepared. A realistic budget, regardless of the source of funding, should be reflective of the consumer's desires and needs. The first step in the PCP process is a snapshot of consumer's dreams, hopes, desires and needs. Some of the techniques used for this have been: Personal Futures Planning; Mapping; PATH; and Lifestyle Planning. The individualized support plan is an attempt to translate the consumer's long-range and short-range goals into a reality by creatively accommodating the existing resources, both financial and human, paid and volunteer, in the form of strategies geared toward the accomplishment of such goals.

When is an "Individualized Support Plan" developed?

The PCP process is conducted periodically, but no less than annually, as needs and dreams of the individual change. The individualized support plan will be developed annually to ensure that it continues to meet the desires and needs of the individual. At any point the PCP team can reconvene to evaluate the support plan and may find that the existing individualized support plan is no longer adequate or relevant to the

changing goals and needs of the consumer. The PCP team should convene whenever there are major changes around the individual. At that time, the PCP team may recommend initiation of a reevaluation of the consumer's hopes, dreams, goals and needs in order to develop a revised individualized support plan.

Who develops the "Individualized Support Plan"?

A PCP team develops the support plan. It's membership will generally include the consumer; his/her legal guardian, if applicable; close family members/advocates; the case manager; providers; a BDDS Service Coordinator; and others identified by the consumer as being important in his/her life. It is important that the consumer make decisions about who should be invited/involved in the PCP team, and/or who should lead the team. Membership of the PCP team may change/fluctuate based on the purpose of meetings and choices of the consumer. Possible PCP Team Facilitators are identified in ***Person Centered Planning Guidelines***:

Any member of the PCP team can complete the Individualized Support Plan document, however the responsibility for assuring the convening of the PCP team and the development of the action/support plan is assigned to:

- The Waiver Case Manager when the consumer is receiving services funded through a Medicaid waiver.

- The BDDS Service Coordinator when the consumer is receiving non-Medicaid waiver funded services through the Bureau of Developmental Disabilities Services (BDDS) of the DDARS.

How is an "Individualized Support Plan" developed?

The individualized support plan is an element in the "Person Centered Planing" process. The initial element provides the larger profile of individual's experiences dreams, personal goals, needs and wants. The individualized support plan is the action plan, which provides creative strategies for translating those long-term and short-term goals and objectives into reality through the maximum utilization of the available resources. The individualized support plan helps convert the individual's dreams, needs and wants as outlined in the PCP process into reality.

For developing a sound individualized support plan, the PCP team will collect all the information required to complete different parts of the individualized support plan. The team should be cognizant of the past, present and future influences of a variety of factors that define the individual's quality of life. Through a review of all available information required by the individualized support plan document, the PCP team develops goals, objectives and strategies for attaining the desired outcomes. The team will provide details of the information in the individualized support plan. The PCP team would identify:

- the person/persons/entity responsible for meeting each one of the established goals;

- the resources, both financial and natural/community supports, available for supporting each one of the established goals; and

- the time-frames for the accomplishment of each one of the support plan goals.

Each member of the PCP team will have the opportunity to agree with the developed individualized support plan based on the consensus or to note objections on the signature page of the individualized support plan document.

Page-By-Page Instructions:

Page 1.

Most information on this page is self-explanatory. It is to be used for a quick reference that records important personal information about the consumer.

- On the first line of the document, the PCP team facilitator enters the date of meeting for preparing the individualized support plan.

- The PCP team facilitator provides his/her name, and the formal organizational affiliation.

CONSUMER-RELATED INFORMATION:

- Complete the last, first and middle name of the consumer.
- Complete the residential mailing address of the consumer.
- Provide consumer's date of birth.
- Provide consumer's social security number.
- Provide consumer's Medicaid number (if applicable and available).
  If the person is not receiving Medicaid funding, write N/A on the line for RID#.

- Provide information about the consumer's current living arrangement, such as lives alone; shares apartment/house with others; lives with his/her family; lives in a Householder for Adults (HHA) or a Householder for Children (HHC) setting; lives in a group home or any other type of institutional setting.

- Provide the gender-related information about the consumer.

- Provide information about the daily routine profile of the consumer by checking the appropriate box: school, employment, other. Briefly explain the "other" category, if applicable.

- The section on decision-making information about the consumer identifies who is legally responsible for making decisions for the consumer. Check the appropriate box for the legal decision-making status of the consumer, whether the consumer is an emancipated adult; an adult with a legal guardian, or a minor.

Please note: a legal guardian refers only to a court-appointed guardian. Minors under eighteen years of age have a legal guardian. The legal guardian may be a child's parent, the local office of Division of Family and Children, or other court-appointed legal guardian. Although an adult consumer may have a very involved parent or a relative, the consumer is considered "competent" unless the court has granted his/her legal guardianship to a parent, a relative or any other person. It is also important to note that many individuals with developmental disabilities may be in need of legal guardianship,

and it may be an unmet need, which needs to be addressed in the individualized support plan.

- If a consumer has a court appointed legal guardian, provide the legal guardian's name, relationship to the consumer, contact address and telephone number. A copy of the guardianship documentation must be retained in the files of the consumer's waiver case manager, BDDS service coordinator, and/or a AAA administrative case manager, as applicable. The PCP team needs to clarify what type of guardianship was granted by the court: a full guardianship; a Limited guardianship (only of the person, or only of the financial resources); or any other type of partial guardianship, such as for health care.

- Provide information about the two closest persons involved in the consumer's life who need to be contacted in times of emergency. Provide the name, telephone number, and mailing address information for the emergency contact persons.

DIAGNOSIS:

The support plan as a document will be used by a variety of people, therefore, please use specific terms to describe the diagnosis of developmental disabilities and not the diagnostic code numbers. Identify one "Primary" and one "Secondary" diagnosis in the order of severity of condition.

*** ATTACH PROFILE INFORMATION:**

As the action/support plan is based on initial profile and discovery information, at least a summary of that information is to be attached to the Individualized Support Plan document. This will allow all entities responsible for elements of the support plan to have some background information at their fingertips regarding the individual's preferences.

Page2.

DECISION-MAKING SUPPORTS:

This section is designed to identify the formal and informal supports available to the consumer in decision-making. This information will also keep the support team informed about whom to contact in a situation, as and when the need arises.

List all of the consumer's available supports for decision-making by checking the applicable boxes. Feel free to check as many boxes as are applicable, and complete the name, address and telephone information.

- Check "Self-advocate" only if the consumer makes important decisions personally.

Please note that an adult consumer without a legal guardian is not automatically considered a "Self-advocate" solely due to the absence of a guardian. A "Self-advocate"

is generally a “competent” person who is actively involved in the decision-making and choice-making in areas of vital influence in his/her life and advocate for himself/herself. On the other hand, having a legal guardian does not and should not limit an individual from advocating for himself/herself in a healthy environment, although, the lines of guardian’s control are clearly demarcated by the legal system.

- Check parent/s if there is involvement in decision-making.
- Check relative, if such a person is a source of decision-making support.
- Check advocate, related or unrelated, including a significant other, if such a person is a source of decision-making support.
- Legal guardian. Also refer to pages 4 & 5 above regarding the details of legal guardian.
- Health care representative (HCR), usually is a court appointed guardian in a limited area of activity, i.e. heath concerns.
- Power of attorney refers to the legal authority of a person over the financial assets and related decisions of another person. The sphere of control is legally defined as confined to financial matters only.
- Financial manager is someone who oversees the financial resources, transactions and records of an individual, although not appointed by the court to do so. It may or may not be a family member. It may be a service provider’s staff or any other involved person in the consumer’s life who manages consumer’s finances.
- Specify in a consistent format, information about any other type of decision-making support/s that are not listed on page 3.

PAGES 3,4, & 5.

OUTCOMES

These 3 pages are broken down into nine (9) boxes for identifying individual’s primary goals from the initial phase of the Person Centered Planning process.

Please note: you may identify as few or as many goals and objectives as needed. You are not limited to nine desired outcomes numerically. Feel free to photocopy these sheets for including additional goals.

The goals may be long-term or short-term. Provide information in the following format for each one of the established goals drawn from the individual’s PCP initial profile element.

Desired Outcomes

Most outcomes will come directly from the goals listed in the consumer’s initial profile element.

Current Status

Through discussion and documentation review, provide information about the individual's current status in the area of activity of the desired outcome.

Past Experience

Through discussion and documentation review provide information about the individual's past experience in the area of activity of the desired outcome.

Proposed Strategies/Activities

Provide detail as to how the outcome will be attained. Take time to look at a variety of options or methods. Multiple strategies can be used to meet one desired outcome. The PCP team needs to assess the preferred strategies through discussion and consumer/guardian/family's 's participation. If possible, clearly outline each strategy and related information.

Responsible Party

List the agency or individual, paid or unpaid, who will be assisting the individual with accomplishing and maintaining the proposed strategies and activities. If the agency or individual is yet to be chosen by the consumer, leave this line blank. Once a "responsible party" has been agreed upon, add the name in this spot and have them sign and date the last page of the Individualized Support Plan document. Every "responsible party" must demonstrate their agreement to provide the proposed activity within the established time frame by signing the last page of the Individualized Support Plan. At any point in which there are major changes in who may be responsible for services, then the PCP team should reconvene so that a smooth transition can take place and the Support Plan can be amended.

Resources

Identify how the proposed activity is to be supported and/or funded. Review the resource options available to the consumer as listed on the Resources Attachment of the Individualized Support Plan.

Please note: ***A Guide for Consumers - Information for Consumers and Their Families*** - July 1, 2001 contains descriptions of the resources listed on the Resources Attachment.

Timeframe

Establishing a realistic time frame for the accomplishment of a desired outcome is vital. Allowing too much, or too little, time will only delay progress. The timeframe should never exceed one year. If it does, the desired outcome needs to be modified. Smaller

steps that are more readily accomplished should be developed. The "responsible party" is also agreeing to work within the timeframe that has been established.

Page 6.

TYPES OF NEEDED SUPPORTS:

- List all supports that the team can locate that will assist the consumer in living as independently as possible.

- Rank order the level of needed supports as "High", "Moderate" or "Low".

- List in an order of priority the supports needed by the individual to live an independent life with enhanced quality.

Examples of needed supports are varied:

supports such as technological devices as aids in daily living skills such as communications/enhanced communications, cooking, self-feeding, mobility, transferring, learning;

supports for learning/strengthening of skills such as the money-management, safety-awareness/alerts, nutrition/healthy eating;

transportation;

behavioral interventions;

medications;

special diets;

social/emotional supports;

decision-making supports, etc.

In this section, include anything and everything that a consumer needs in his/her life to maximize personal independence.

Page 7

LIST OF CURRENT "UNMET" NEEDS OF THE CONSUMER:

There may be some dreams, preferences, or needs of the consumer that have been identified as goals during PCP, but are not reflected in the section on "Outcomes" of the

individualized support plan document. It is possible that there may be no funding, and/or necessary resources available to the individual; it may not be a high priority goal of the individual; or there may be a need for the attainment of other skills by the consumer before it can becomes feasible. If there are any unmet needs, document them in the provided space and briefly state why a particular need is not being actively addressed at this time.

Page 8

INDIVIDUALIZED SUPPORT PLAN PARTICIPANTS:

Special attention needs to be given to this section.

- It is important that the full name and actual signatures are obtained from each participant at the individualized support plan meeting.
- Each PCP team member must also identify the nature of his/her relationship to the consumer and/or the name of the organization of affiliation.
- Each participant at the individualized support plan meeting must indicate whether he/she agrees or not with the action/support plan as prepared and/or with the respective assignment/s.

Although each participant at the individualized support plan meeting may not receive/volunteer for assignments, by signing this page and checking that they support the individualized support plan, each participant becomes committed to the successful implementation of the action/support plan and accountable for carrying out the assigned tasks within the prescribed time frames.

Even if the service provider implements the activity in a timely manner, this may not result in the accomplishment of the desired outcome. Many factors influence learning and achievement. If a proposed strategy doesn't result in accomplishing the goal, and the goal is still desired by the consumer, then the issue needs to be revisited, and new strategies need to be developed.

If a PCP Team member disagrees with all, or part, of the Individualized Support Plan, he/she has the option of checking the box that indicates he/she does not "support the plan". The team member then needs to attach a response that explains his/her concerns.

The On-going Process:

Once the Individualized support plan has been finalized, and the document has been completed, all PCP Team members will be given a copy, unless otherwise directed by the consumer. Make sure the consumer is consulted as to his/her preference regarding the Plan's distribution. All Team members who have been named as the "responsible party" for any of the desired outcomes must receive a copy of the action/support plan.

The latest Individualized Support Plan document must be available for review in the consumer's primary place of residence at all times.

The Waiver Case Manager and the BDDS Service Coordinator are responsible for monitoring the progress on the proposed activities and time frames. The PCP Team should be reconvened as soon as necessary, but no less than annually, to review the desired outcomes and to make any other changes as indicated by the consumer. When the consumer's PCP Team has revisited and revised the individual's current reality and desired outcomes, the Individualized Support Plan must be updated within ten (10) days.

RESOURCES ATTACHMENT

This attachment may also be helpful when developing the ICLB, Plan of Care or Individual Plan for Employment.

The Resources Attachment provides a list of sources that may be available or are already being used by the consumer to support the consumer's needs and wants. The support plan facilitator may complete this part after reviewing and discussing with the PCP team, consumer & consumer's representatives the sources that are suitable and available to meet consumer's needs. The last three sections provide for the "Other" category to include any resources, which are not on this list, but are available to the consumer.